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ABSTRACT

Examined was the incidence of severe, moderate, and mild behavior disorders in regular grades K-12 in 13 Florida county school districts. Twelve to 20 teachers in each school idstrict were provided with definitions of behavior disorders and asked to identify the number of children in their classes with various degrees of disorder and also to provide additional information on the children such as age, sex, race, and academic achievement level. Among findings were that a mean of 20% of children were perceived by their teachers as requiring special services for behavioral disorders (12.6% mild, 5.6% moderate, and 2.2% severe); and that there was a gradual increase in the incidence level between kindergarten and grade 5, a decline between grades 6 and 8, the highest incidence at grade 9, followed by a sharp decline to the lowest incidence of all grades in grade 12. Other findings were a consistently higher reported incidence of behavioral disorders for males, for black children, and for academically underachieving children. (DB)

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BEHAVIOR DISORDERS: AN INVESTIGATION OF TEACHERS' PERCEPTIONS

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INTRODUCTION

Recent passage, in many states, of mandatory legislation and court decisions have unequivocably established that the school boards have the obligation to provide adequate education for ALL children and youth. This "ALL" includes all the handicapped, whether the deficit is intellectual, sensorial, behavioral, or motoric. (Mondale, 1972) Legal developments have had many highly positive effects primarily in the expansion of specialized services for children and youth who, until recently, have been deprived of those services which would assist them in performing at an optimal level. Provisions aimed at optimizing the development of human resources is in keeping with the goals established by the Joint Commission of Mental Health (1969). The Commission outlines several inalienable rights of each individual:

1. The right to be wanted.
2. The right to be born healthy.
3. The right to live in a healthy environment.
4. The right to satisfaction of basic needs.
5. The right to continuous loving care.
6. The right to acquire the intellectual and emotional skills necessary to achieve individual aspirations and to cope effectively in our society.

Even though state and federal mandates and court decisions are providing impetus for services to the handicapped, it must not be assumed that all is bliss. Rather, with any good there are inevitably some undesirable features. One aspect that should cause concern for all educators is the accurate identification of children and youth who would benefit from specialized services. Identification is closely akin to the establishment of definitions in that it is not feasible to begin screening and identification procedures without first developing a frame of reference which assists in the designation for special services.

The Behaviorally Disordered

Delineation of acceptable definitions of the handicapped population is a most difficult task; however, the problem becomes most acute in defining the behaviorally disordered population who have been variously referred to as the "emotionally disturbed", "socially maladjusted", and "educationally handicapped." Some of the reasons for

the lack of agreement in defining this population may be partially accounted for in that there are a large number of professionals whose purpose is to work with children and youth who present discrepancies in expected behaviors. These professionals represent the fields of social work, psychology, psychiatry and education. Professionals from the various disciplines frequently have very diverse orientations and consequently view asynchronous behavior very differently. This is most vividly seen in the kinds of therapeutic goals that are established by the professionals involved.

Numerous attempts have been made to establish a definition applicable to the behaviorally disordered population. Listed below are a few definitions that have frequently appeared in the literature.

1. "...One who because of organic and/or environmental influences, chronically displays: (a) inability to learn at a rate commensurate with his intellectual, sensory-motor and physical development; (b) inability to establish and maintain adequate social relationships; (c) inability to respond appropriately in day-to-day life situations, and (d) a variety of excessive behavior ranging from hyperactive, impulsive responses to depression and withdrawal" (Haring, 1963).
2. "...Behavioral disabilities are defined as a variety of excessive chronic, deviant behaviors ranging from impulsive and aggressive to depressive and withdrawal acts (1) which violate the perceiver's expectations of appropriateness, and (2) which the perceiver wishes to see stopped" (Graubard and Miller, 1968).
3. "The child who cannot or will not adjust to the socially acceptable norms for behavior and consequently disrupts his own academic progress, the learning efforts of his classmates, and interpersonal relations" (Woody, 1969).
4. "...One whose progressive personality development is interfered with or arrested by a variety of factors so that he shows impairment in the capacity expected of him for his age and endowment; (1) for reasonably accurate perception of the world around him; (2) for impulse control; (3) for satisfying and satisfactory relations with others; (4) for learning; or (5) any combination of these" (Joint Commission, 1969).
5. "A child is emotionally disturbed when his reactions to life situations are so personally unrewarding and so inappropriate as to be unacceptable to his peers and adults. Thus disturbed children are viewed as having limited patterns of behavior and lacking flexibility to govern and modify their behavior" (Pate, 1963).
6. "A child is disturbed when his behavior is so inappropriate that regular class attendance (1) would be disrupting for the rest of the class, (2) would place undue pressure on the teacher, or (3) further the disturbance of the pupil" (Pate, 1963).
7. "Emotionally handicapped (disturbed) children can be perceived as children who demonstrate one or more of the following characteristics to a marked extent (acute) and over a period of time (chronic):

1. an inability to learn which cannot be explained by intellectual, sensory, or health factors;
2. an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. inappropriate types of behavior or feelings under normal conditions;
4. a general, pervasive mood of unhappiness or depression; and,
5. a tendency to develop physical symptoms, pains, or fears associated with personal or school problems" (Bower, 1960).

As can be seen from the above presentation of attempts at defining the behaviorally disordered population, there are some generally accepted characteristics or symptoms but it is virtually impossible to designate an individual for certain special services based upon the content of any or all of the espoused definitions. Furthermore, there are certain questions that will assist in putting the designation of behaviorally disordered in the proper perspective.

1. From what discipline is the professional making the designation?
2. An individual's behavior is discrepant from what?
3. What is the acuteness and chronicity of the problem described?
4. Under what circumstances does the behavior exist?

The Teacher's Role in Identification

No one is more intimately involved with the total cognition and emotional development of children and youth than the classroom teacher, primarily because in our culture "school is the occupation of children." If this is true, then teachers should logically be in a position to make reasonably accurate recommendations regarding those children and youth who would benefit from some type of specialized service designed to enhance their academic and emotional development. It is probably too much to ask teachers to make appropriate referrals, however, by providing only one or more of the definitions appearing in the literature. Possibly a more effective and efficient procedure is to isolate specific behaviors to which teachers can respond in terms of their frequency of occurrence and the apparent magnitude of the problem. Research (Ellis and Miller, 1936; Nelson, 1971) indicates that teachers can be highly efficient in the identification of problem areas presented by children and youth when given some behavioral parameters to assist in their decision-making.

Regardless of designated labels or the accuracy of identification, whenever teachers indicate that an individual presents a problem, for any reason, the situation demands the attention of some capable school official and further investigation. In order to provide school districts with information which would be beneficial for program and facility planning for those who may be recognized as presenting behavioral problems in some degree, whether severe, moderate, or mild, an investigation was conducted of classroom teacher's perceptions of behavioral disorders in children and youth who were enrolled in their classes. The various aspects of this study will be discussed in subsequent sections of this manuscript.

REVIEW OF RELEVANT LITERATURE

The study of maladjustment among our nation's school aged children and youth has been of major interest to researchers. Since 1925, when the first major study was undertaken, numerous research methodologies have been emplcyed in an effort to more precisely define the nature and scope of the problem. Primarily, because of the lack of agreement among mental health professionals with regard to the criteria to be used in discriminating between adequate adjustment and maladjustment, a number of diverse estimates of the prevalence of maladjustment have been published. Therefore, it is evident that until some agreement on criteria can be reached, each research investigation concerned with the prevalence of maladjustment should be examined on the basis of it's particular methodology and application to various planning and program efforts.

Incidence Studies

Glidewell and Swallow's (1968) review of the incidence studies conducted between 1925 and 1967 indicate that approximately 30 percent of elementary school-aged children have some type of adjustment problem. However, approximately 10 percent of elementary school-aged children probably require some type of clinical intervention. Glidewell and Swallow (1968) also reported that about four percent of elementary school-aged children are referred for clinical assistance or would be referred if the appropriate facilities and programs were operational.

Possibly the most frequently cited estimate of the incidence of maladjustment in school-aged children is that of Eli Bower (1960). According to Bower, approximately 10 percent of the school-aged population need professional help of some kind during their school years, although less than one percent of school-aged children have severe emotional problems requiring intensive intervention programs. Services for the less severe population may include offerings presently available in many schools today such as individualized testing, guidance and counseling, whereas the more severe will require psychological, psychiatric and/or specialized educational programs.

On the basis of the various studies which have been conducted, the United States Office of Education, Bureau for the Education of the Handicapped, (Dunn, 1973) suggests that a two percent estimate be used as a starting point in planning programs for emotionally disturbed children and youth. The two percent estimate essentially refers to those children and youth with more severe problems. If consideration were given to a broader range of child behavior problems presented by children and youth, this estimate would have to be increased considerably. Again, it should be noted that we are still far from a consensus in regard to adequately defining the nature and severity of emotional problems among children and youth.

Types of Incidence Studies

A detailed examination of the literature on the incidence of behavioral disorders among school-aged children and youth would involve attention to numerous studies which have been done over the past 40

years. As mentioned above, Glidewell and Swallow (1968) prepared a rather extensive review for the Joint Commission on the Mental Health of Children. Of particular relevance to the present investigation are investigations of the "Referral" type. These are investigations which essentially require classroom teachers to identify those children and youth who they would refer for special services (i.e. special education, child guidance clinic), if such services were available. As a contrast to the referral type investigation, selected studies of teacher and clinical judgments of children's adjustment were included. These studies employed specific types of criteria and/or test instruments. Finally, attention was given to some of the major variables which have been associated with maladjustments in school-aged children.

Teacher and Clinical Judgments

One of the earliest and most recognized investigations of maladjustment in children was conducted by Wickman (1928). This study was primarily concerned with school adjustment as rated by classroom teachers. The teachers were asked to rate and indicate the frequency of undesirable behaviors in 874 pupils from a Cleveland, Ohio elementary school, grades 1 - 6. The criteria used in determining maladjustment was the presence of one or more of 51 behaviors which, at some point in time, caused considerable or serious difficulty. On this basis, the teachers identified 53 percent of their pupils as maladjusted to some degree. However, when the same children were rated by clinicians, a number of significant discrepancies were found between their judgments and those made by teachers. The teachers were apparently most concerned with acting out or agressive kinds of behavior as a sign of poor adjustment, while the clinicians were more sensitive to children who appeared to be withdrawn. However, these differences can probably be attributed in part to the fact that the teachers and the clinicians in this investigation were given different instruction to follow in rating the children's behavior.

Since Wickman's (1928) study, a number of researchers have attempted to determine if there are significant differences between teachers' and clinicians' ratings of children's behavior. Peck (1935) found that teachers could be taught to judge like clinicians when they were exposed to a summer course in child psychology. In an attempt to replicate Wickman's (1928) study, Ellis and Miller (1936) concluded that teachers could recognize the seriousness of withdrawing behavior as well as other behavioral disturbances in children. Ullman (1952) also was interested in determining if teachers could identify those children who needed psychological assistance. A high correlation was found between the judgments of teachers and clinicians. It was concluded that teachers and clinicians were much more in agreement in respect to children's behavior problems than earlier studies had indicated. Nelson (1971) has also found that teachers can usually distinguish between normal children and those exhibiting behavioral disorders. When teachers' ratings were compared with scores derived from a direct classroom observation technique, those children rated by their teachers as conduct disordered engaged in significantly more deviant behavior and significantly less task oriented behavior.

The prevalence of maladjustment in school-aged children was also investigated by Rogers (1942). A weighted index, which included teacher ratings, academic standing, chronological age, grade placement, truancy and several personality tests, was used to evaluate 1500 elementary school children in the Columbus, Ohio public schools. Thirty percent of the children were judged to have been moderately maladjusted while 12 percent were found to have been seriously maladjusted. Variations in the rate of maladjustment were noted from school to school. According to Rogers, these variations were related to possible differences in the criteria regarding maladjustment, educational policies and the characteristics of the school population. A rather similar rate of maladjustment was noted by Glidewell, Gildea, Domke, et.al. (1959) when they investigated the problem of maladjustment among 830 third grade children in the St. Louis, Missouri public schools. A combination of teacher's ratings, mother's reports, and sociometric choices were utilized by the investigators. Twenty-eight percent of the children were given an overall rating of mildly maladjusted. Slightly more than eight percent were rated as having serious adjustment problems.

Cowen, Izzo, Miles, et.al. (1963) studied the mental health of 108 children in grades 1, 2 and 3 in a Rochester, New York elementary school. A number of sources of data were used. These included teacher estimates of ability, school achievement records, parent interviews, self tests, and clinical and teacher ratings of behavior. After comparing these various measurement techniques, it was concluded that 37 percent of the children were maladjusted.

A study (Mental Health Research Unit, 1964) of 6,788 pupils in grades 2 and 4 from the public schools in Onondage County, New York indicated that 15 percent of the children were mildly maladjusted while 7.6 percent were clinically or more severely maladjusted. These data were collected by having the teachers identify those children who they considered to be problem children. From within the problem group they were asked to identify those who they considered to be emotionally disturbed.

Referral Type Investigations

The incidence of maladjustment among school-aged children and youth has also been investigated on the basis of teacher referrals. Teachers have been asked to submit the names of students who appeared to be in need of special services or programs for behavioral disorders.

McClure (1929) requested that teachers in grades 1 - 8 and special classes of the Toledo, Ohio public schools identify those children who they thought should be referred to some type of juvenile agency (i.e. child guidance clinic, etc.). A questionnaire which included six categories of undesirable behavior was provided as a guide for the teachers. Two percent of the 23,364 children who were considered were recommended for referral.

A referral rate of two percent was reported by Glidewell and Stringer (1961) in a study of 530 third grade children in St. Louis, Missouri when the teachers were asked to refer those children who they believed needed mental health services. It was determined that the

ratings given by these teachers correlated with other measures of adjustment such as parental ratings, sociometric choices and clinical judgments.

A total of 588 students in grades 4, 5 and 6 from the Lansing, Michigan public schools was used as subjects in Maes' (1966) investigation of maladjustment. A referral rate of 6.9 percent was determined on the basis of referrals to a local child guidance clinic by teachers and parents.

White and Charry (1966) conducted a rather extensive study in which they included a total of 49,918 students in grades K - 12 in Westchester County, New York. As in Maes' (1966) investigation, the referrals of teachers and parents were tabulated. The teachers and parents were instructed to list those children and youth who they believed were in need of referral to a school psychologist. A referral rate of 4.8 percent was determined.

In each of the above referral type investigations numerous questions regarding the judgments of the individual making the referral can be raised. Other intervening variables such as wide variations between socio-economic groups, the age levels sampled, variations in school achievement and sex differences may also be considered in determining the accuracy of results from referral type investigations. However, if referral rates are considered as indicators of teachers' concerns and not diagnostic in nature, they can be interpreted and utilized effectively in initiating programs for children and youth with behavioral problems

Variables Related to Incidence

As already mentioned, a number of variables have been found to be related to the incidence of behavioral disorders in children and youth in public school populations. Bower (1961) found that the incidence of emotional handicaps was highest among upper elementary and junior-high school-aged children. Morse, Cutler and Fink (1964), as part of a national study of programs for the emotionally disturbed, indicated that about two-thirds of the educational programs for the emotionally disturbed were being implemented at the upper elementary and junior-high school levels. Bullock and Brown (1972), in a study of emotionally disturbed children in the Florida public schools, noted that most of the programs for these children were concentrated at the elementary school level (K - 6).

Sex differences are also quite apparent in research in the area of behavioral disorders. Gilbert (1957) indicated that acting out type behavior problems were four times more prevalent in boys than girls. White and Harris (1965) found that boys outnumbered girls by at least two to one while Morse, Cutler and Fink (1964) reported a ratio of five to one with boys being predominant. Bullock and Brown (1972) found that 73 percent of the children receiving special education services for behavioral disorders were boys.

Quite characteristic of children and youth with behavioral disorders is usually their lack of satisfactory achievement in school subjects. Gilbert (1957) found that achievement problems were frequently found among children referred to local clinics. Bullock and Brown (1972) also found that a large majority of emotionally disturbed children were functioning below grade expectancy. Morse, Cutler and

Fink (1964) concluded that a significant number of those children and youth identified as emotionally handicapped were also classified as underachievers.

Race and socio-economic status also have been found to be related to the incidence of behavioral disorders. For example, Rosen, Bahn and Kramer (1964) indicated that the rates of mental health problems among non-whites are higher during adolescence and adulthood but lower during the early childhood years of 3 to 11. According to Douglas (1959) the rate of juvenile delinquency in blacks is twice as great when compared with whites. Such factors as prejudice, unstable family structures, and limited educational opportunities are no doubt related to the higher incidence rate among blacks. Glidewell and Swallow (1968) point out that race and class differences are compounded. Higher rates of behavioral disorders may be more a function of social class rather than race. Although racial differences in the elementary grades have not been adequately researched, classroom management problems have been found to be more common in the inner-city slum schools.

When researchers have attempted to isolate socio-economic status as it relates to behavioral disorders the findings have not been conclusive. A higher incidence of disturbed children from families whose fathers were classified as "semi-skilled" or "unskilled" workers was reported by Bower (1961). Children of fathers who were classified at the professional or managerial levels were less likely to have been included as having behavioral disorders. Hollingshead and Redlich (1958) also found a significantly higher incidence of disturbed children of parents whose occupations were classified as "unskilled" or "semi-skilled". However, White and Charry (1966) found no significant social-class differences when they compared referred and non-referred children in Westchester County, New York.

Summary

Studies of maladjustment in school-aged children and youth have led to a much greater understanding of the nature and the scope of this most critical problem. Research in this area is most difficult, particularly because of the lack of agreement in regard to specific criteria to be used in determining personal and social maladjustment.

Research efforts can be classified into types, including measures of school maladjustment, clinical maladjustment and referral type investigations. Research primarily concerned with defining school maladjustment problems has resulted in a wide range of incidence figures, some reported as including forty to fifty percent of the sample under investigation. Clinical and referral type studies which typically have focused on the most severely maladjusted children and youth, those usually in need of special services outside the school, have provided incidence figures which range from one or two percent to as high as 20 percent of the sample in question.

Numerous investigations have examined the accuracy of teachers' judgments regarding student adjustment. Comparisons have been made between the judgments made by teachers, parents, clinicians, peers and other significant persons in the child's environment. To date,

a great deal of evidence exists which indicates that teachers can make accurate judgments about the mental health of their students.

Several variables associated with maladjustment in children and youth have been investigated in some detail. These have included age, sex, academic achievement, race and socio-economic status. In general, relatively strong relationships have been determined with regard to age, sex and academic achievement. Studies involving race and socio-economic factors have been relatively less conclusive in demonstrating a relationship with maladjustment in children and youth.

Although much further investigation is needed, there exists sufficient data to assist planners who have been charged with the responsibility of initiating new and innovative programs for the behaviorally maladjusted. The dissemination of all available data is particularly important at this time when there is an increased interest in program development and when the availability of resources is apparent.

RESEARCH PROCEDURES

Preliminary Considerations

The problems associated with accurately determining the incidence of behavioral disorders in children and youth are extremely complicated. Among these problems is the decision as to which professional agency is to be sampled. Studies of the incidence of behavioral disorders may be conducted in mental health centers, juvenile courts, hospitals, schools, etc. Any particular setting is likely to contribute to decisions regarding the type and severity of the reported problems. Behavioral problems, as reported by mental health center personnel, most likely will be of a more serious nature since their clients probably will have passed through a number of processes on their way to a center. Children with mild behavioral problems may be assisted at home or in school before a referral to a mental health center is deemed necessary. On the other hand, school personnel are more likely to identify a wider range of behavioral problems, including classification such as mild, moderate, and severe problems. Both those who are emotionally disturbed as well as those who are disturbing to teachers and their peers may be listed by school personnel as behaviorally handicapped.

The personal opinion of the observer influences how a behavioral disorder is defined. For example, a teacher may be threatened by the acting out child and ignore withdrawn behavior. The theoretical orientation of the professional observer will also influence attempts at defining a problem. One teacher may view masturbation as expected while another teacher may hold a totally contrary point of view. Still another discrepancy in regard to definition may arise as a function of the professional orientation or discipline of the observer. Teachers, for example, may view behavior in terms of achievement while a psychologist may think in terms of how well the child gets along with his peers (Woody, 1969).

Prior research activities involving teachers in the identification of children and youth with behavioral disorders have utilized a variety

of methods, namely behavior rating scales, intelligence tests, achievement tests and sociometric techniques. It also has been quite common for teachers' judgments regarding behavior to be compared with judgments made by clinicians. The utilization of these screening methods often involves subjective judgments about behavior by teachers and clinicians or the use of a particular test instrument which may or may not be an accurate index of the mental health of the child.

The major purpose of the present investigation was to determine how the behavior of children and youth was perceived by their teachers. Instead of asking the teachers to rate their pupils in terms of selected behavioral dimensions (i.e. degree of interaction with peers, nervous habits, etc.) each teacher was asked to identify those children who they believed were in need of certain kinds of special programs or services as defined by the investigator. Three broad program or service categories were defined and presented to the participating teachers as part of a research survey form (Appendix A). The three major special programs or services were also associated with three general degrees of behavioral disorders; mild, moderate, and severe.

1. Mild Behavioral Disorders
   Children or youth with behavioral disorders who can be helped adequately by the regular classroom teacher and/or other school resource personnel through periodic counseling and/or short term individual attention and instruction.
2. Moderate Behavioral Disorders
   Children or youth with behavioral disorders who can remain at their assigned school but require intensive help from one or more specialists (i.e. counselors, special educators) and/or specialists from community agencies (i.e. mental health clinics, diagnostic centers).
3. Severe Behavioral Disorders
   Children or youth with behavioral disorders who require assignment to a special class or special school.

The participating teachers were asked to respond to the above definitions while assuming that all of the suggested services were feasible and available. Each of the suggested programs or services were selected and defined as above on the basis of their broad acceptance by special educators as educational alternatives for the mild, moderate and severely behaviorally disordered child or youth.

The research survey form used in the present investigation was not designed to eliminate all of the problems associated with accurately defining behavioral disorders as suggested above. The form was designed so that the participating teachers were free to make their judgments about their students' behavior without being influenced by suggested definitions of behavioral disorders. No attempt was made to precisely define what constituted maladjustment or a behavioral disorder. It was intended that the findings of the present investigation be reported in terms of teachers' perceptions with no attempt made to substantiate or refute these perceptions within the scope of the present investigation. The findings were intended to be indicative of how the participating teachers currently perceived their students rather than their assessment of behavioral dimensions that may or may not be valid criteria for good mental health.

Rationale

Why ask teachers to report their perceptions of their pupil's behavior? Why not pose these questions to professional mental health clinicians? The major justification for selecting teachers to respond to the research survey form was the amount of time that teachers spend each day with this segment of the population. Teachers are in a position to observe children and youth for extended periods of time and under varied conditions. Clinicians typically see individuals for relatively brief periods of time and usually on a one to one or small group basis. In addition to these obvious advantages, previous research, as already described, has indicated that teachers and clinicians often are in agreement when they are asked to make judgments about children's mental health. Finally, it is most important that teachers' perceptions of their pupils be known. Children and their teachers spend many thousands of hours together. If perceptions are in need of change, a necessary first step is a determination of the nature of these perceptions.

Sample

A total of thirteen county school districts in the State of Florida were selected for inclusion in the present investigation. After a pilot study was completed in one of the counties, twelve other counties were selected on the basis of their school enrollments. Four districts (small size districts) with enrollments of less than 10,000 pupils, five districts (medium size districts), including the pilot district with between 10,001 and 30,000 pupils and four districts (large size districts) with enrollments in excess of 30,000 pupils were included in the total sample.

Approximately 10 to 20 teachers per grade level (K - 12) in each county district were included in the sample to permit grade level comparisons. However, the sample (Tables 2 and 3) from each grade level varied in respect to the size of the particular district, availability of the teachers (i.e. illness) on the day the survey was administered, and the degree of the cooperation extended to the local survey team.

Specific Instructions

The research survey of the pilot district was personally conducted by the investigators and a team of graduate research assistants. Subsequently, the special education directors or coordinators in each additional participating district were contacted personally and/or by telephone. The purpose and the procedure for the survey were explained to the local directors. In addition, detailed instructions for the administration of the survey were printed and mailed to each director and survey administrator.

Meetings were held at the local district levels between the special education director or coordinator and the various district staff members who agreed to assist in the administration of the survey. Time was allowed for questions and answers between the investigator and the survey teams at the local district levels. The local schools were selected at random for participation. Only two school principals

chose not to have their school included in the survey. After each building principal agreed to allow faculty participation, a date and time was set for the administration of the survey. A time when each faculty was together as a group was determined. In most cases general faculty meetings or curriculum meetings were utilized.

Each teacher was instructed to bring a copy of the class roster to the faculty meeting on the date the survey was administered. The roster was to be used as a point of reference while completing the survey form. Each school faculty was provided with specific and uniform verbal instructions by a survey team member on how to correctly respond to the survey form. The entire procedure including the instructions, dissemination, teacher response and collection of the survey forms took approximately twenty minutes. However, additional time was provided for those teachers who requested extra time to complete the form.

Only teachers of "normal" children were asked to participate in the survey. These included regular class teachers of English, reading, mathematics, etc., in addition to other specialized areas such as art, music and physical education. Special class teachers of the mentally retarded, the emotionally disturbed, etc., were not asked to participate since one important intent of the investigation was to assess teachers' perceptions of those children not previously assigned to special self-contained classes. Also, special itinerant and resource teachers were not asked to participate since the children they serve are assigned to regular classes and could be reported by their teachers.

Upon completion of the survey form, a spot check of the form was made by the survey team administrator. The forms were then forwarded to the investigator for final checking and tabulating. Forms, which indicated evidence of misunderstanding or inaccuracy by the teachers were discarded. Less than 1% of the forms were not utilized for this reason.

Related Data

Each teacher was asked to supply additional information about their students in addition to the major categories of mild, moderate, and severe behavioral disorders. Information regarding the sex, race, and achievement levels of the children and youth was requested (Appendix A). Finally, the teachers were asked to provide basic information about themselves such as their age, years of teaching experience, race, educational preparation grade level, school and district. In some cases, for various reasons, all of the teacher-related information was not reported. Nevertheless, no survey forms were discarded because certain teacher-related information was omitted. However, the omission of specific information items by the participating teachers accounts for the differences in the number of teachers reporting on certain aspects of the present investigation.

FINDINGS

The findings relevant to the present investigation should be of significant interest to program planners and others interested in services for the behaviorally disordered. A concerted effort has been made to highlight those findings which should prove helpful in determining program priorities.

The general findings are organized under three major dimensions:

1. The overall incidence of behavioral disorders as perceived by classroom teachers is presented. In addition, incidence figures are presented by school district, grade level and degree of disorder.
2. Several other possible factors related to behavioral disorders in children and youth are discussed. These include the sex and race of the children and teachers, underachievement of the children and educational preparation of the participating teachers.
3. The data is also presented in terms of incidence levels. For example, the number of teachers that perceived between zero and ten percent of their students as exhibiting a behavioral disorder was determined. Each incidence level (i.e., 11%-20%, 21%-30%, etc.) is listed in relation to the general category of behavioral disorders in addition to a breakdown with respect to mild, moderate and severe behavioral disorders.

Overall Incidence Reports

The total mean percent of children and youth identified by their classroom teachers as exhibiting behavioral disorders was 20.4. The data is presented in Table 1. Approximately one out of every

TABLE 1

Children and Youth Perceived by Teachers (N=2664) as Requiring Special Services for Behavioral Disorders

Degree of Disorder	$\bar{X}$%
Mild	12.6
Moderate	5.6
Severe	2.2
Total	20.4

five children or youth considered were perceived by their teachers as having, to some degree, a behavioral disorder. More specifically, 18.2 percent of the children identified by the 2,664 participating teachers were perceived as having mild (12.6%) or moderate (5.6%) behavioral disorders with 2.2 percent classified as having severe problems. These are obviously very awesome figures when calculated in terms of actual student enrollment in the counties participating in the present investigation; however, these data are reported in terms of overall averages with significant variations among the participating teachers. These variations will be presented as part of the present investigation.

An analysis of teachers' perceptions of their students by county school district is presented in Table 2. School districts with

TABLE 2

Children and Youth Perceived by Teachers and Reported by School District as Requiring Special Services for Behavioral Disorders

District (Code No.)	Participating Teachers	All Categories $\bar{X}$%	Mild $\bar{X}$%	Moderate $\bar{X}$%	Severe $\bar{X}$%
Small (less than 10,000)					
9	51	10.2	8.5	1.7	0.0
12	160	13.5	8.6	3.5	1.4
2	147	20.0	13.6	4.6	1.8
6	167	22.7	13.0	6.1	3.4
Medium (10,001 - 30,000)					
1	207	16.9	10.5	4.6	1.8
10	180	18.6	11.3	5.0	2.3
5	143	19.2	12.0	5.6	1.6
8	351	21.9	13.8	6.1	2.0
13	279	25.4	16.0	6.4	3.0
Large (30,001 - or more)					
3	135	17.8	12.3	4.2	1.3
11	238	18.3	10.2	6.1	2.0
4	275	21.5	13.5	5.7	2.3
7	324	24.5	14.0	7.1	3.4

(N=2657)

relatively small student enrollments (less than 10,000 students) were compared with districts categorized as medium in size (between 10,001 and 30,000 students) and large districts (30,001 or more students). Although no definite trend in regard to school district size was evident, Counties* Number 9 and 12 (10.2% and 13.5% respectively), classified as "small" counties, reported relatively lower incidences of children and youth with behavioral disorders. County Number 11, a large county, reported a total of 18.3 percent for all categories with County Number 6, a small county, reporting an incidence figure of 22.7% for all categories. With respect to the categories of mild, moderate and severe behavioral disorders a rather consistent ratio between these categories is apparent.

The teachers' perceptions of their children in terms of grade level is presented in Table 3. It is possible to report on the

TABLE 3

Children and Youth Perceived by Teachers and Reported by Grade Level as Requiring Special Services for Mild, Moderate and Severe Behavioral Disorders

Grade	Number of Classes	Mild $\bar{X}$%	Moderate $\bar{X}$%	Severe $\bar{X}$%	All Categories $\bar{X}$%
K	96	12.3	5.0	2.1	19.4
1	180	14.6	6.3	2.6	23.5
2	163	15.7	5.8	2.4	23.9
3	182	13.4	7.7	3.1	24.2
Ungraded (K-3)	53	12.0	6.7	2.5	21.2
4	190	14.5	7.4	3.1	25.0
5	178	14.0	8.3	2.8	25.1
6	199	13.5	6.1	2.4	22.0
Ungraded (4-6)	32	19.0	9.1	1.9	30.0
7	148	11.8	5.7	2.4	19.9
8	117	10.4	6.4	2.8	19.6
9	135	16.6	6.3	3.1	26.0
Ungraded (7-9)	107	11.7	6.0	2.5	20.2
10	93	10.7	3.2	0.8	14.7
11	65	11.4	3.1	0.7	15.2
12	44	6.2	1.6	1.0	8.8
Ungraded (10-12)	395	9.1	2.4	1.0	12.5

(N = 2377)

* Each county district was assigned a code number for dissemination purposes.

perceptions of only 2,377 teachers with respect to grade level since almost 300 teachers chose not to indicate the grade they were teaching. A total of 587 of the participating teachers indicated that they were teaching in non-graded classes. Those findings have been organized and reported in separate non-graded categories within Table 3. An effort was made to sample an equal number of teachers at each grade level, but school organizational patterns, among other factors, prevented an equal distribution. This was particularly evident at the high school level where many of the teachers reported that they were teaching in non-graded classes. A total of 395 teachers indicated that they taught tenth, eleventh and twelfth graders in a combined group situation.

The incidence levels for all categories by grade levels are represented in Figure 1. A gradual increase in the percents of children

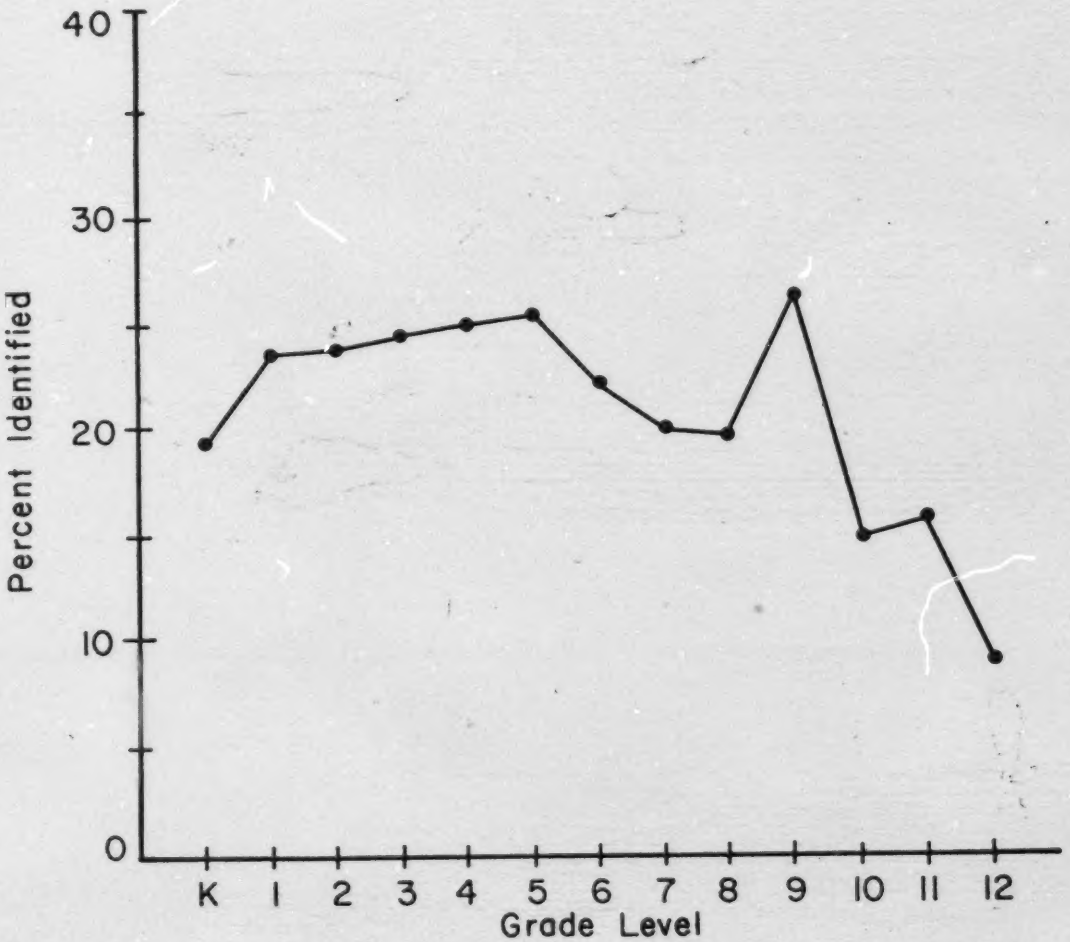


Figure 1. Children and Youth Perceived by Teachers (N=1790) and Reported by Grade Level as Requiring Special Services for Behavioral Disorders

and youth with behavioral disorders is evident between kindergarten and the fifth grade. After a decline between grades six and eight, the highest incidence was reported at grade nine. A sharp decline is evident

between grades ten and twelve with the exception of the slight increase in grade eleven. The non-graded class data, Figure 2, indicated some

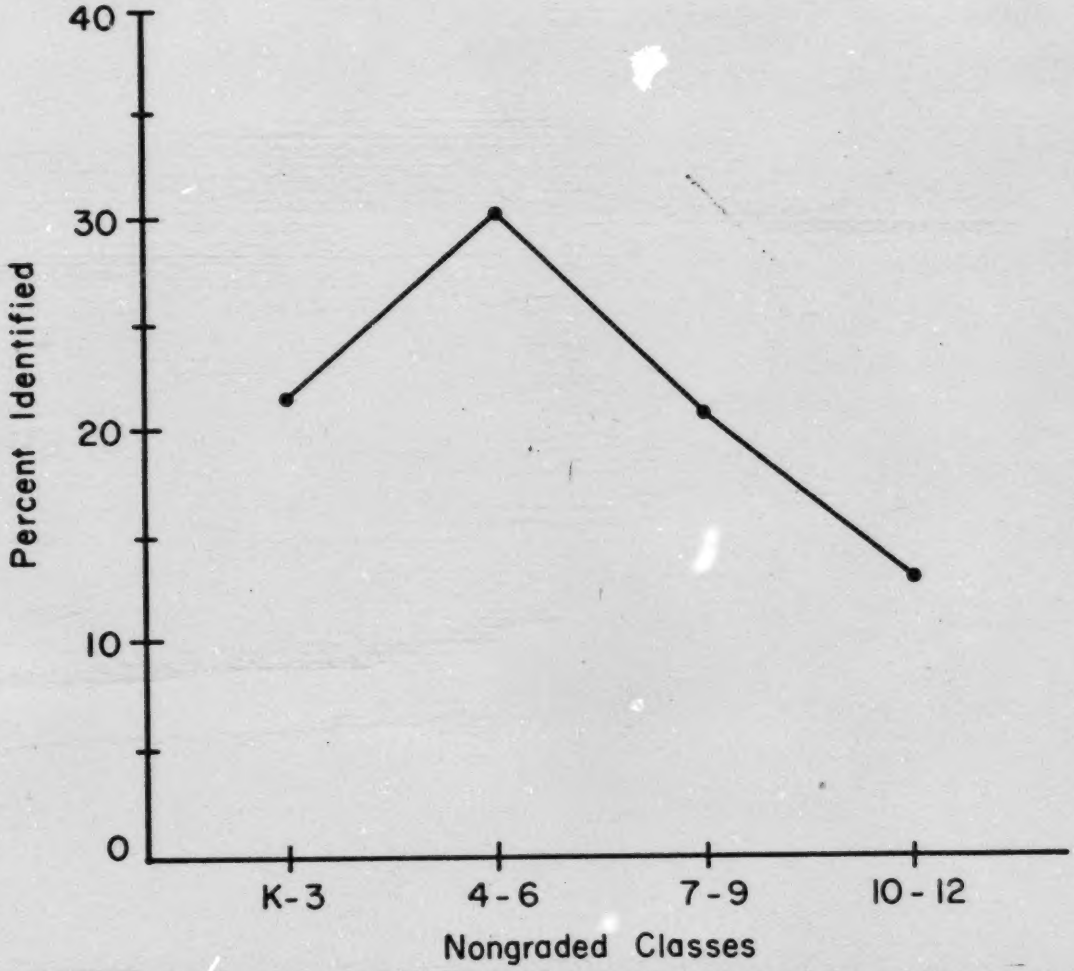


Figure 2. Children and Youth Perceived by Teachers (N=587) in Nongraded Classes as Requiring Special Services for Behavioral Disorders

differences when compared to the graded class data. The teachers of the non-graded classes (4-6) reported a total incidence of 30 percent for all categories compared with percents of 25.0, 25.1 and 22.0 for the graded classes four, five and six respectively. However, the relatively small sample of non-graded class teachers (n=42) likely produced a more biased result when compared with the larger samples from the fourth, fifth and sixth grade levels. Another discrepancy is evident in the non-graded classes (7-9), where it might be expected that the incidence level would exceed the reported figure of 20.2 percent since the teachers of the ninth grade students reported an incidence level of 26.0 percent. Ninth graders within the non-graded classes (7-9) were perceived by their teachers as either less deviant or were counterbalanced by fewer identifications of seventh and eigth grade students in the non-graded classes (7-9).

In addition to the analysis of the overall incidence of behavioral disorders by grade level, a further breakdown in terms of mild, moderate and severe categories of behavioral disorders by grade level is presented in Table 3 and Figure 3. The incidence of mild behavioral disorders

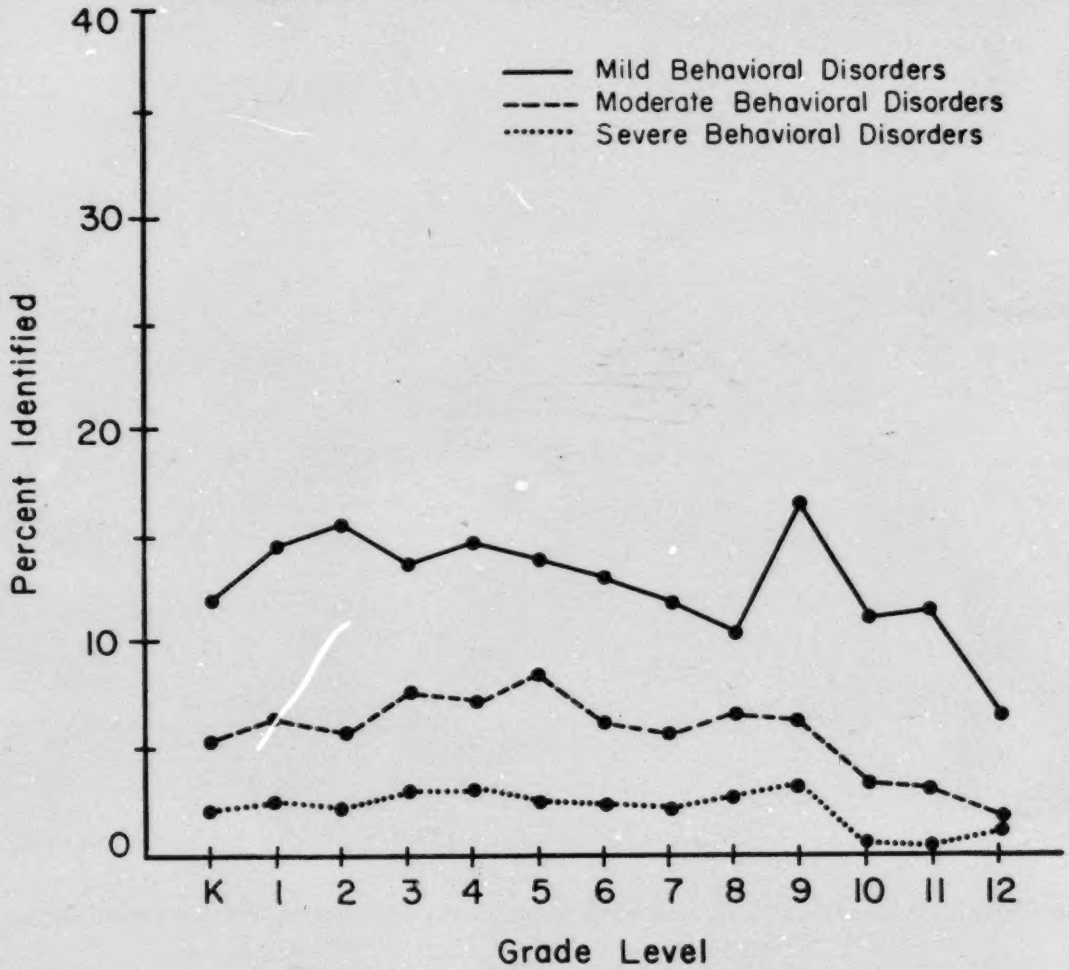


Figure 3. Children and Youth Perceived by Teachers (N=1790) and Reported by Grade Level as Requiring Special Services for Mild, Moderate and Severe Behavioral Disorders

reaches an initial peak at the second grade level as compared with an initial peak at the fifth grade level for all categories as reported in Figure 1. The teachers reported an increase in the incidence of children and youth with moderate behavioral disorders up to the fifth grade with a gradual decline up to and including grade twelve. Only at grades eight and nine are very minor increases noted before the incidence level for moderate disorders continues its downward trend in the high school grades. By way of contrast, the teachers' perceptions of children with severe behavioral disorders maintain a very stable incidence level of approxamately 2 percent to 3 percent between kindergarten and grade

nine with a sharp decline in grades ten, eleven and twelve.

Incidence levels for mild, moderate and severe behavioral disorders for the non-graded classes appear to follow a trend similar to the graded classes. The data is graphically presented in Figure 4. An

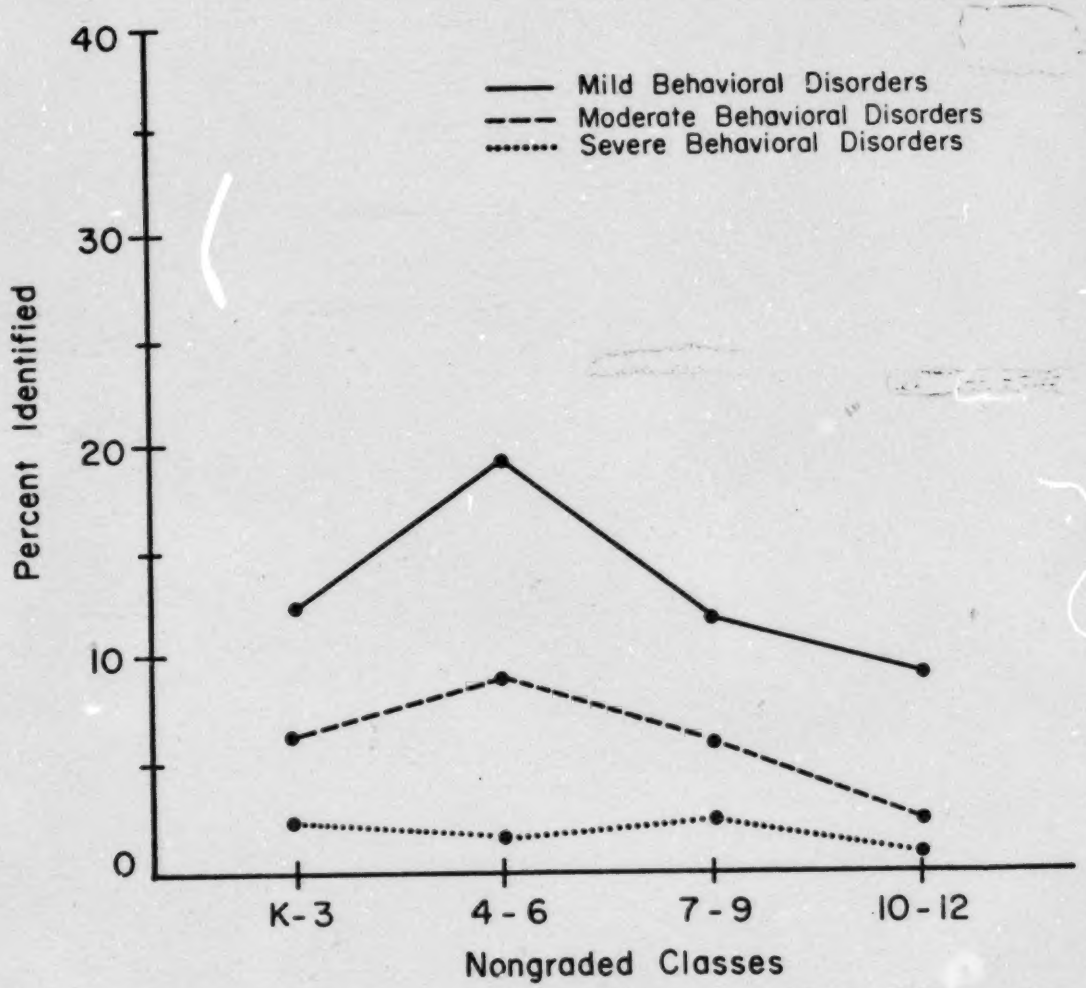


Figure 4. Children and Youth Perceived by Teachers (N=587) in Nongraded Classes as Requiring Special Services for Mild, Moderate and Severe Behavioral Disorders

exception to these conforming patterns can be noted for the non-graded classes (4-6). Incidence levels for mild and moderate disorders were relatively higher for the non-graded classes (4-6) but lower for severe behavioral disorders when compared with the fourth, fifth and sixth grades in Table 3. Again, as noted earlier, the small sample of 32 teachers may have resulted in a biased sample.

FACTORS RELATED TO BEHAVIORAL DISORDERS

Sex

A significant factor related to the incidence of behavioral disorders has been the sex of the children or youth under investigation. The tendency to identify many more males than females is illustrated in Table 4. An initial inspection of the data reveals an approximate ratio

TABLE 4

A Comparison of Behavioral Disorders in Males and Female Children and Youth as Perceived by All Teachers (N=2306) and Reported by School District

School District (Code Numbers)	Rank	Males $\bar{X}$%	Rank	Females $\bar{X}$%
8*	----	----	----	----
7	(1)	30.3	(3)	15.9
13	(2)	29.4	(1)	19.9
6	(3)	26.7	(2)	17.1
4	(4)	26.0	(4)	14.7
10	(5)	25.9	(9)	11.8
1	(6)	23.8	(8)	12.0
2	(7)	23.6	(5)	13.7
11	(8)	22.7	(9)	11.8
5	(9)	23.0	(6)	12.5
3	(10)	21.5	(6)	12.5
12	(11)	16.3	(11)	10.4
9	(12)	11.9	(12)	8.5

* Data not requested

of two to one or higher. For example, County Number 7, a large county, which ranked second in the overall identification of behaviorally disordered children and youth, Table 3, reported 30.3 percent of its male students as exhibiting behavioral disorders as contrasted to the identification of 15.9 percent of its female students.

In general, the school district rankings by the sex of the children, Table 4, were quite consistent with the combined school district rankings as reported in Table 2. One rather significant difference in the data was noted in the case of County Number 1. This county ranked eleventh in the combined male-female rankings by district, Table 2, but ranked sixth in the ranking of male suudents, Table 4. County Number 10 ranked higher, fifth, in respect to male students as contrasted to the overall ranking of eighth for male and female students. However, the size of the difference in terms of percent is relatively small (3.2%) when one considers that the identification of 25.9 percent of the male students in County Number 10 places the county in fifth place. A reduction of this percent to 22.7 percent would change the ranking of County Number 10 to eight. Several other minor differences between the rankings reported in Table 4 and Table 2 can be noted upon further inspection of the data.

The teachers' perceptions of male and female students by grade level are illustrated in Figure 5. An initial inspection reveals that the

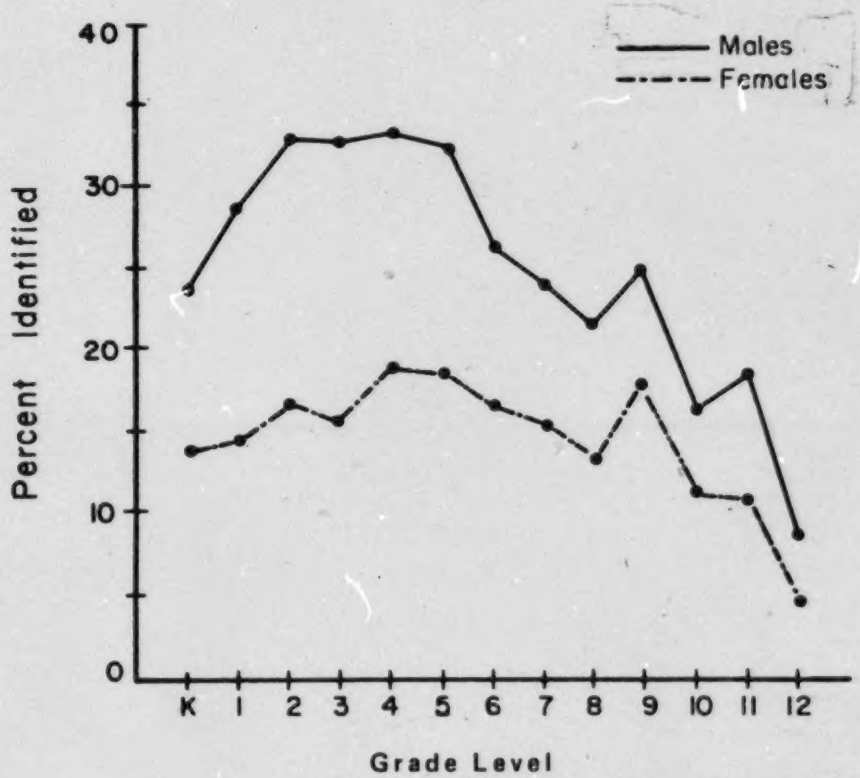


Figure 5. A Comparison of Behavioral Disorders in Male and Female Children and Youth as Perceived by Teachers (N-1574) and Reported by Grade Level

greatest differences in the incidence of behavioral disorders between male and female students occurred in grades 1-5. Somewhat smaller differences were noted at the kindergarten, sixth, seventh and eighth grade levels. At the upper grade levels there was a tendency on the part of the teachers to minimize the sex factor when designating children and youth as behaviorally disordered. A very similar pattern of difference between male and female students was noted for the non-graded classes reported in Figure 6.

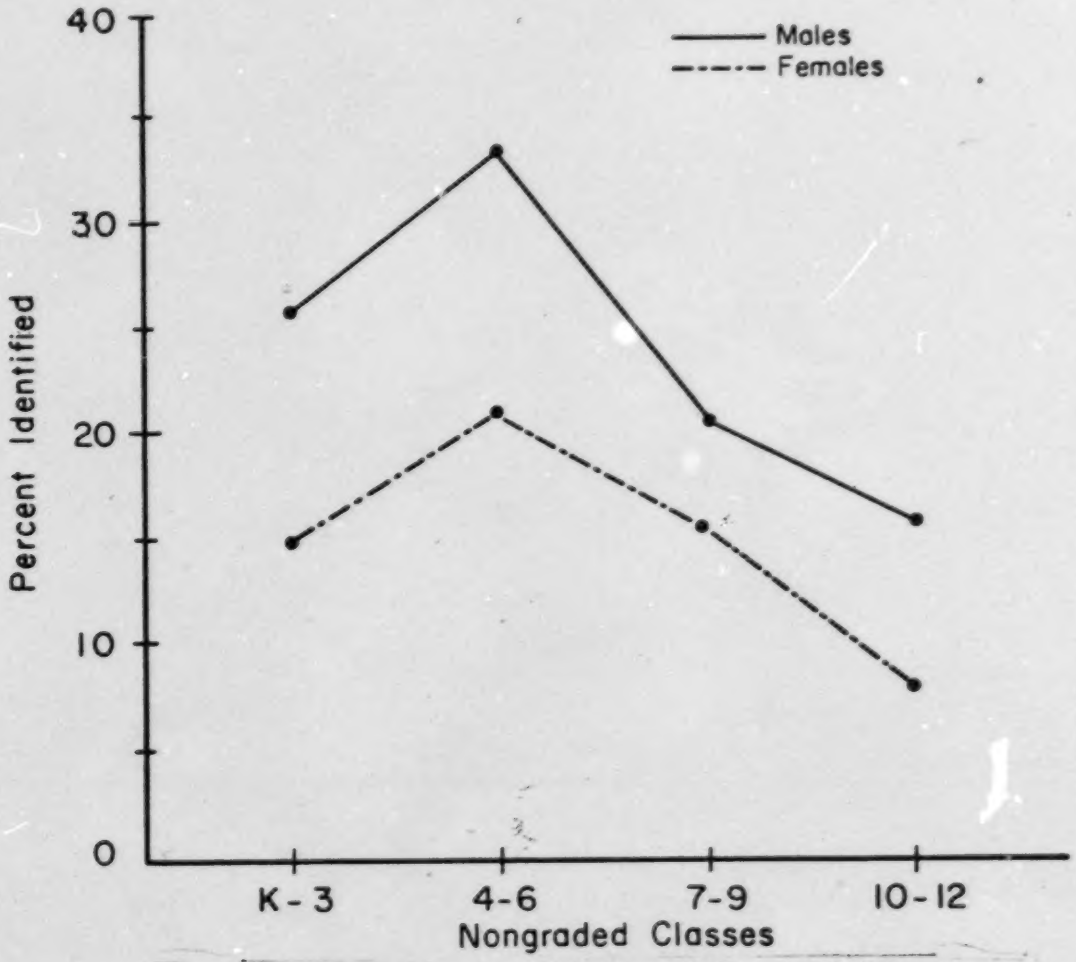


Figure 6. A Comparison of Behavioral Disorders in Male and Female Children and Youth in Nongraded Classes as Perceived by Teachers (N=520)

Race as a factor in the incidence of behavioral disorders in children and youth has been of significant interest to educators. Although much research needs to be done in this area, several studies (Rosen et.al., 1964, Douglas, 1959) have indicated a relationship between race and the incidence of behavioral disorders. The incidence of behavioral disorders among Blacks tends to be higher when compared with incidence figures for

Whites. A similar trend is noted upon inspecting the data in Table 5.

TABLE 5

A Comparison of Behavioral Disorders in White and Black Children and Youth as Perceived by All Teachers (N=2306) and Reported by School District

School District (Code Numbers)	Rank	White $\bar{X}$%	Rank	Black $\bar{X}$%
8	----	----	----	----
7	(1)	20.1	(4)	28.9
13	(2)	18.6	(4)	28.9
2	(3)	17.6	(6)	28.7
6	(4)	16.7	(2)	30.9
4	(5)	16.7	(3)	30.3
10	(6)	15.7	(1)	36.5
5	(7)	15.6	(10)	23.5
11	(8)	15.1	(7)	28.0
3	(9)	14.3	(9)	23.6
1	(10)	13.1	(8)	25.6
12	(11)	12.1	(12)	16.1
9	(12)	6.3	(11)	17.1

Each of the participating school districts was compared with respect to the percents of black and white children and youth perceived by their teachers as behaviorally disordered. In several of the districts, the ratio of behavioral disorders reported for black students in comparison to white students approached two to one, with one of the districts, County District Number 10, exceeding this ratio. In general, those districts occupying a particular place in ranking with respect to incidence among white students occupied a quite similar place in the rankings in respect to black students. Certain exceptions can be noted upon a further inspection of Table 5.

An analysis of the teachers' perceptions of behavioral disorders among black and white children by grade level (k-12) is reported in Figure 7. A pattern similar to that found in Figure 5, a comparison

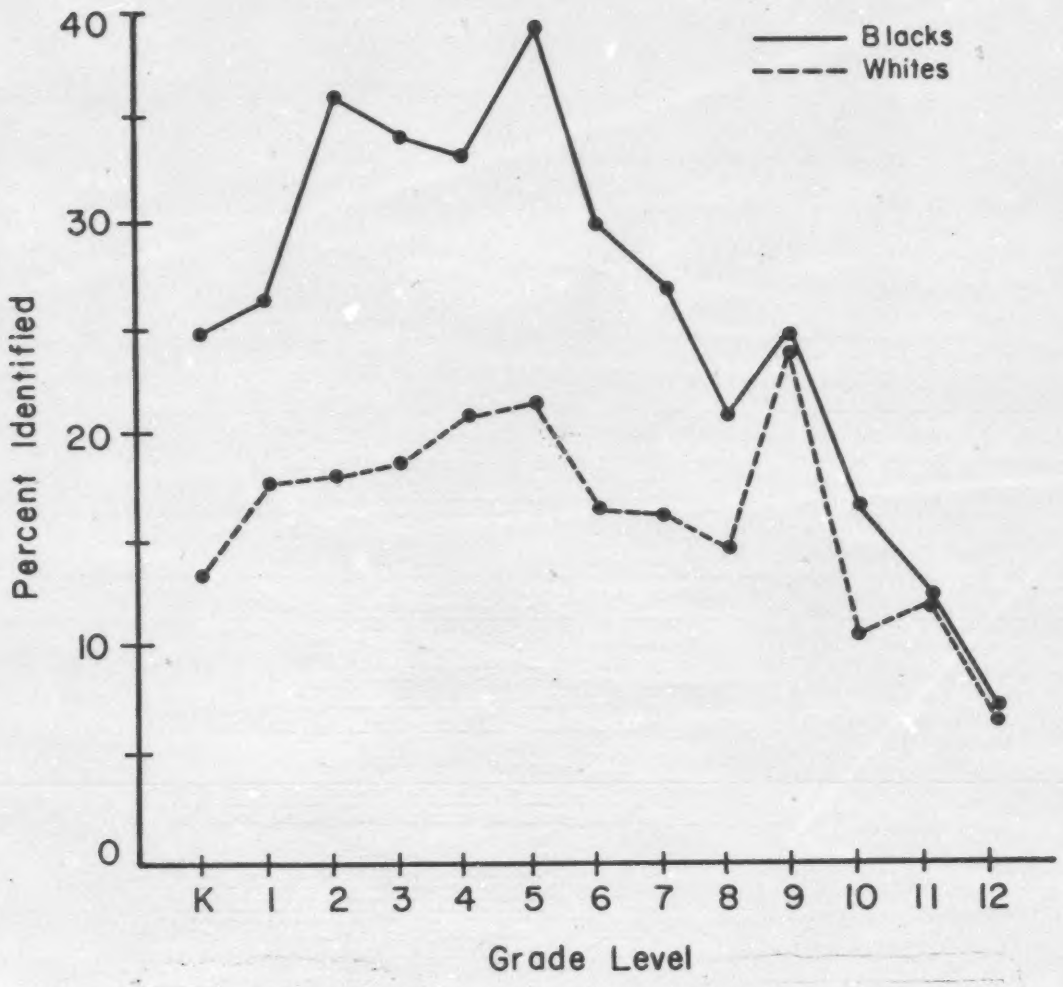


Figure 7. Black and White Children and Youth Perceived by All Teachers (N=1574) and Reported by Grade Level as Requiring Special Services for Behavioral Disorders

between males and females, can be noted. The participating teachers perceived greater percents of black children as having behavioral disorders, especially in grades kindergarten through grade 7. Teachers in the upper grades, grade eight through grade twelve, perceived fewer differences between Blacks and Whites with respect to behavioral disorders. A similar pattern of teachers' perceptions can be noted for the ungraded classes in Figure 8.

Academic Achievement

Another significant factor related to behavioral disorders in children and youth is underachievement in academic subject areas. A comparison between behavioral disorders and underachievement by school district is provided in Table 6. Each participating teacher was asked to indicate the number of children or youth in his or her class that was perceived as behaviorally disordered and underachieving. Underachievement was defined as student performance that was below the student's appropriate grade level.

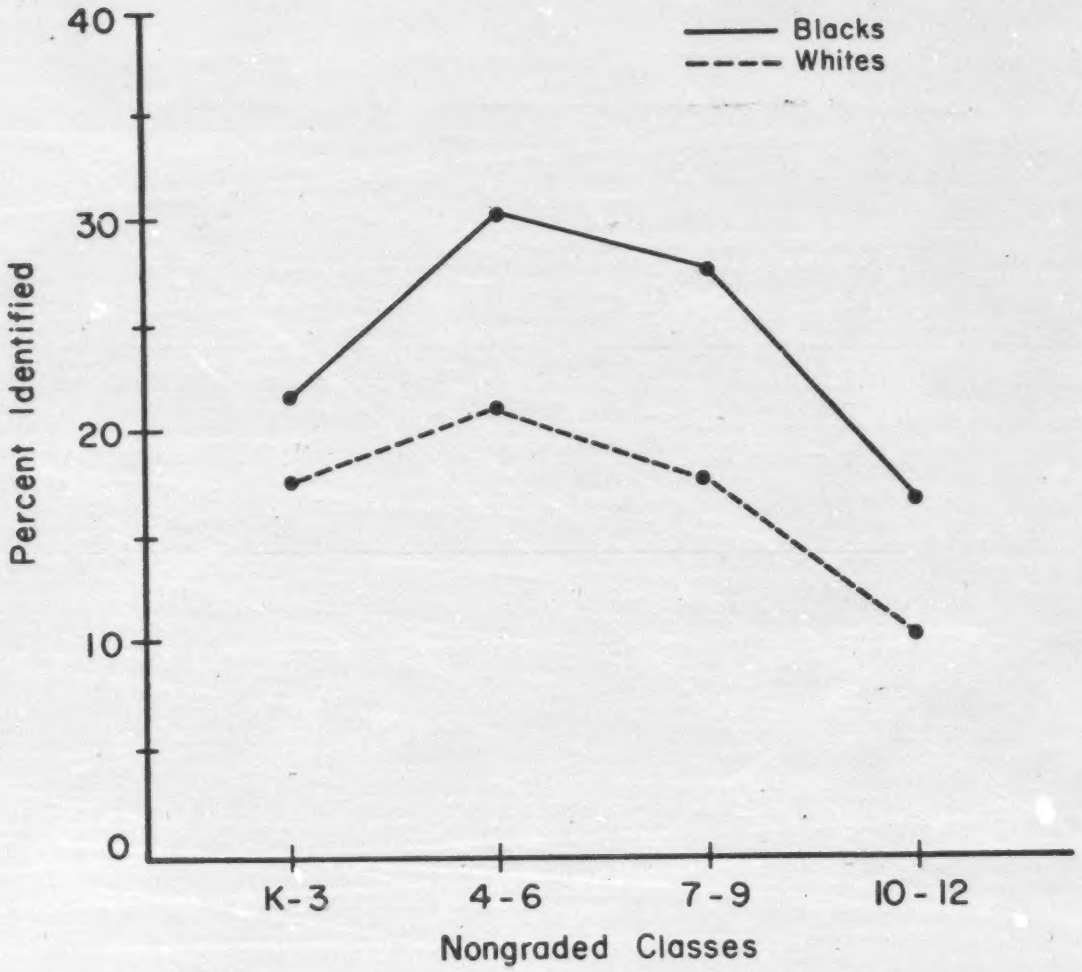


Figure 8. Black and White Children and Youth Perceived by All Teachers (N=520) in Nongraded Classes as Requiring Special Services for Behavioral Disorders

The data presented in Table 6 substantiates earlier research findings which associated behavioral disorders with underachievement (Morse, et. al., 1964, Gilbert, 1957). For example, in County Number

TABLE 6

A Comparison of Behavioral Disorders
and Underachievement of Children and Youth
as Perceived by Teachers (N=2657)
and Reported by School District

School District (Code Numbers)	Underachievement $\bar{X}$%	Behavioral Disorders $\bar{X}$%
Small		
9	35.0	10.2
12	32.4	13.5
2	43.4	20.0
6	39.9	22.7
Medium		
1	34.6	16.9
10	51.0	18.6
5	36.9	19.2
8	52.6	21.9
13	46.9	25.4
Large		
3	32.1	17.8
11	38.5	18.3
4	45.2	21.5
7	41.8	24.5

9, the participating teachers perceived 10.2% of their students as exhibiting some type of behavioral disorder. Thirty-five percent of those children and youth so identified were seen as not achieving at the appropriate grade level. Underachievement among those perceived as exhibiting behavioral disorders ranged from a low of 32.1% in County Number 3 to a high of 52.6% in County Number 8.

The possible relationship between behavioral disorders and underachievement by grade levels is presented in Figure 9. For most of the grade levels, the teachers perceived approximately one-half of the behaviorally disordered as having problems with achievement. The kindergarten, tenth and twelfth grade teachers were less inclined to characterize the behaviorally disordered children as underachievers. With respect to the non-graded classes, Figure 10, the teachers of non-graded classes, K-3 and 10-12, identified relatively fewer underachievers as compared to the teachers of the other non-graded classes 4-6 and 7-9.

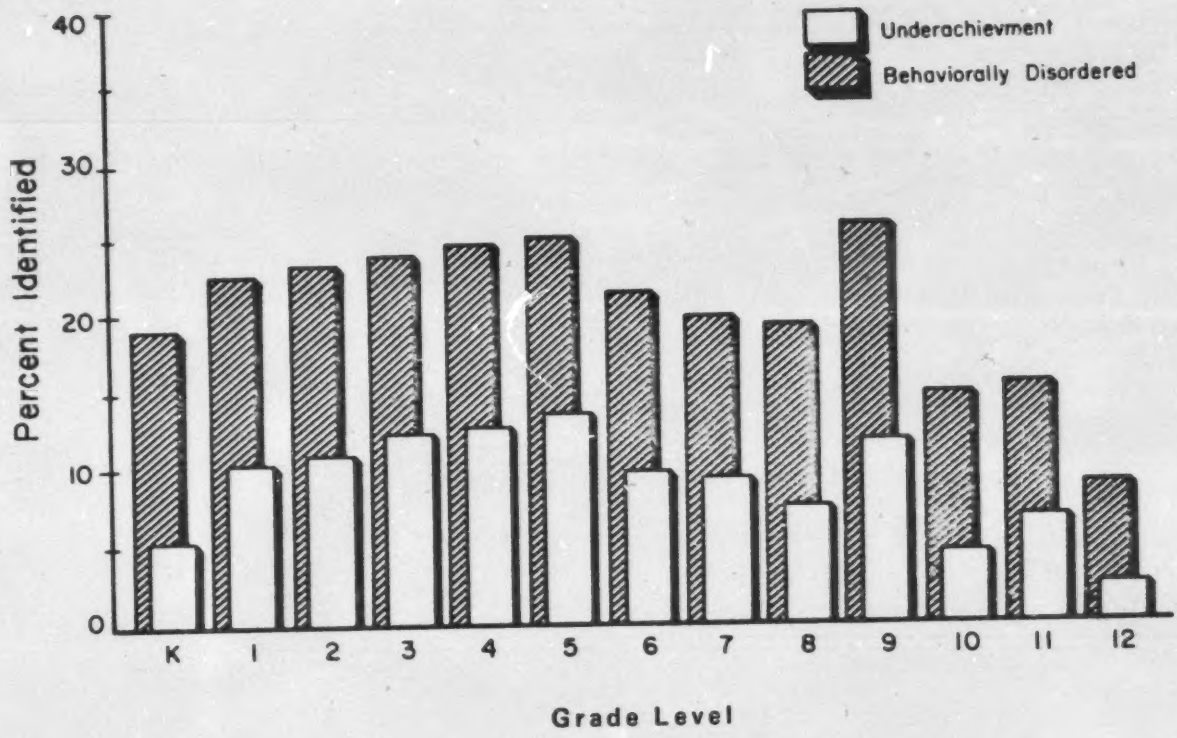


Figure 9. A Comparison of Behavioral Disorders and Underachievement of Children and Youth as Perceived by Teachers (N-1790) by Grade Level

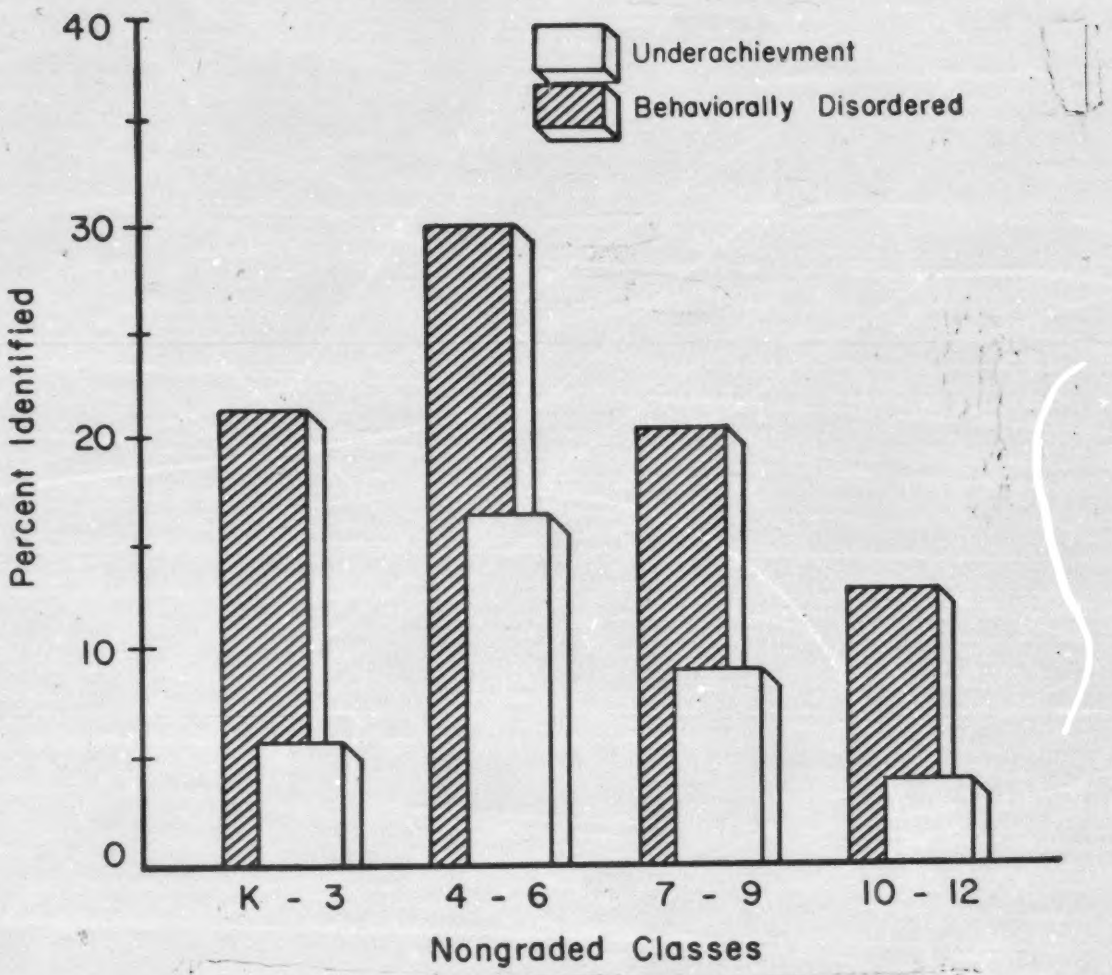


Figure 10. A Comparison of Behavioral Disorders and Underachievement of Children and Youth in Nongraded Classes as perceived by Teachers (N-587)

Teacher Characteristics and Behavioral Disorders

The data relevant to each teacher's perceptions of the students' behavior was supplemented by additional descriptive data on each participating teacher. Each teacher was asked to indicate sex, number of years of teaching experience, race or ethnic background, and level of formal educational preparation. All of the accumulated data pertaining to the students was matched with the teachers and their perceptions.

The perceptions of the male and female students as they were reported by male and female teachers are reported in Table 7. With respect to each of the categories of behavioral disorders, the female teachers perceived slightly higher percents of children or youth with behavioral problems. For example, the male teachers identified 18.1 percent of their students as exhibiting some degree of behavioral disorder while the female teachers

TABLE 7

Children and Youth Perceived by Male and Female Teachers as Requiring Special Services for Behavioral Disorders

Sex of Teacher	All Categories $\bar{X}$%	Mild $\bar{X}$%	Moderate $\bar{X}$%	Severe $\bar{X}$%
Male (N=712)	18.1	11.7	4.4	2.0
Female (N=1812)	21.4	12.9	6.1	2.4

identified 21.4 percent.

An analysis of the data reported by the teachers according to the years of teaching experience is provided in Figure 11. Teachers'

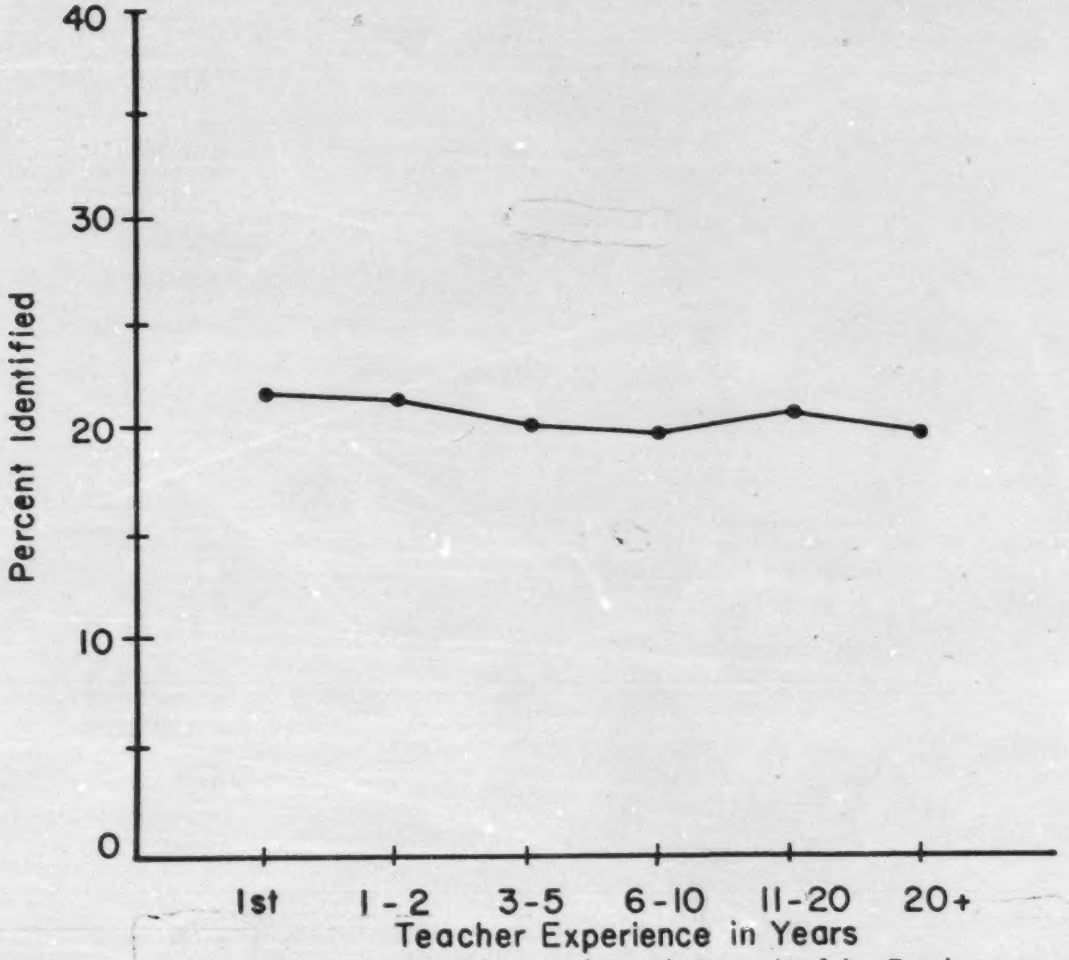


Figure 11. Children and Youth Perceived by Teachers (N=2608) With Various Years of Experience as Requiring Special Services for Behavioral Disorders

perceptions of children and youth with behavioral disorders did not appear to be related to any great degree by teaching experience levels. It may be of some interest to note that a very slight decline in the percents of children identified as behaviorally disordered occurred between the first year of teaching and the six to ten year experience category.

The perceptions of the black and white teachers with respect to their black and white students is reported in Table 8. Perceptions

TABLE 8

A Comparison of Behavioral Disorders in White and Black Children and Youth as Perceived by All White and Black Teachers

Race of Teacher	White Children and Youth $\bar{X}$%	Black Children and Youth $\bar{X}$%
White (N=1712)	15.6	27.3
Black (N=451)	17.9	24.7

reported by teachers of Spanish-American origin and other race or ethnic backgrounds were omitted in this report due to the relatively small number of teachers who identified themselves as belonging to these categories. The white teachers tended to report slightly fewer white children and slightly more black children than their black teacher colleagues; however, the differences are rather minimal.

The perceptions of the male and female teachers regarding their male and female students indicated somewhat greater differences when compared with the race factor. The female teachers perceived a greater number of both male and female students as exhibiting behavioral disorders. The male teachers were not inclined toward identifying as many of their students as indicated by the data in Table 9.

TABLE 9

A Comparison of Behavioral Disorders in Male and Female Children and Youth as Perceived by All Male and Female Teachers

Sex of Teacher	Male Children and Youth $\bar{X}$%	Female Children and Youth $\bar{X}$%
Male (N=673)	21.1	11.8
Female (N=1575)	26.6	15.0

The final teacher variable, which was matched with teacher perceptions, was educational background. The investigators were particularly interested in determining whether teachers with formal professional preparation in the field of Education could be differentiated from their colleagues who had not majored in Education. In addition to the field of Education, each teacher was assigned to a category which most appropriately described their formal university or college preparation. For example, those who had majored in Psychology, Sociology or a related discipline, were classified in the area of Humanities. Those who had been chemistry or biology majors were classified in the area of Sciences. All of the teachers who did not appear to fit any of the above categories were assigned the category entitled "Other".

An initial inspection of Table 10 reveals that the Education

TABLE 10

Children and Youth Perceived by Teachers With Various Educational Backgrounds as Requiring Special Services for Mild, Moderate and Severe Behavioral Disorders

Degree	Participating Teachers	All Categories $\bar{X}$%	Mild $\bar{X}$%	Moderate $\bar{X}$%	Severe $\bar{X}$%
Bachelors Major					
Education	989	21.9	13.0	6.2	2.7
Humanities	336	19.4	11.5	5.6	2.3
Sciences	166	18.2	11.7	4.6	1.9
Other (Not included above)	72	16.6	10.3	4.3	2.0
Masters Major					
Education	285	21.2	12.6	6.2	2.4
Humanities	54	17.1	11.2	4.3	1.6
Sciences	37	13.0	9.1	2.8	1.1
Other (Not included above)	11	21.7	9.7	6.6	5.4

majors at both the bachelor's and master's levels perceived higher percents of children and youth as exhibiting some degree of behavioral disorder. Although the differences between the various teacher preparation categories appear to be relatively slight, a consistent pattern at the bachelor's and master's degree levels was apparent.

That is, the teachers with formal preparation in Education perceived the highest percent of children and youth with behavioral disorders followed by those with majors in the Humanities, the Sciences, and finally those teachers classified as "Other".

Tables 11, 12, 13 and 14 are included to provide the reader with an analysis of the teachers' perceptions regarding behavioral disorders according to ten selected incidence levels. At this point, the investigators were interested in knowing how many teachers identified children and youth within each of the ten selected incidence levels. For example, with respect to the teachers' overall perceptions of children and youth with behavioral disorders, Table 11, including all degrees of disorder, 1003 teachers or 37.7 percent of the teachers sampled, perceived between 1-10 percent of their children and youth as behaviorally disordered. Twenty-eight or 1.1 percent of the teachers sampled identified between 90 percent and 100 percent of their students as behaviorally disordered. Obviously, this type of presentation of the data suggests a variety of possible speculations regarding the mental health status of both the students under consideration and the teachers who have reported their perceptions. Tables 12, 13 and 14 provide a similar presentation of the data but with respects to the various degrees (mild, moderate and severe) of behavioral disorder included in the research survey form. As one proceeds through Tables 12, 13, and 14, it becomes apparent that the number of teachers perceiving lower percents of behavioral disorders increases rapidly. For example, in Table 13, which depicts the teachers' perceptions of moderate disorders, the number of teachers reporting between zero and ten percent increased to 2,119 as compared to the 1,402 teachers who reported between zero and ten percent in the mild category, as indicated in Table 12. Subsequently, 2,486 teachers, in Table 14, reported between zero and ten percent of the students as having severe behavioral problems.

Obviously, it is only natural to expect this type of trend in the data as behavioral disorders of a more severe degree are considered. However, it should be noted that relatively significant numbers of teachers designated high percents of students as behaviorally disordered. For example, in Table 13, 14.1 percent or 375 of the teachers designated between 11 and 20 percent of their students as exhibiting moderate behavioral disorders. Also, 5.1 percent or 137 teachers perceived between 11 and 20 percent of their students as exhibiting severe behavioral disorders.

A significant amount of data relevant to how classroom teachers perceive the behavior of their students has been reported. Many inferences and judgments can be offered by both the reader and the investigators with regard to the meaning and significance of the data for those engaged in planning and developing educational and treatment services for children and youth.

TABLE 11

Percent of Teachers Perceiving Children and Youth as Behaviorally Disordered in Each of Ten Incidence Levels

Incidence Level %	Number of Teachers	Percent of Teachers
0 - 10	1003	37.7
11 - 20	635	23.8
21 - 30	384	14.4
31 - 40	270	10.1
41 - 50	160	6.0
51 - 60	76	2.9
61 - 70	40	1.5
71 - 80	46	1.7
81 - 90	22	0.8
91 - 100	28	1.1
Totals	2664	100.0

TABLE 12
Percent of Teachers Perceiving Children and Youth as Having Mild Behavioral Disorders in Each of Ten Incidence Levels

Incidence Level %	Number of Teachers	Percent of Teachers
0 - 10	1402	52.6
11 - 20	702	26.4
21 - 30	332	12.4
31 - 40	117	4.4
41 - 50	59	2.2
51 - 60	25	0.9
61 - 70	13	0.5
71 - 80	5	0.2
81 - 90	4	0.2
91 - 100	5	0.2
Totals	2664	100.0

TABLE 13

Percent of Teachers Perceiving Children and Youth as Having Moderate Behavioral Disorders in Each of Ten Incidence Levels

Incidence Level %	Number of Teachers	Percent of Teachers
0 - 10	2119	79.6
11 - 20	375	14.1
21 - 30	118	4.4
31 - 40	33	1.2
41 - 50	10	0.4
51 - 60	2	0.1
61 - 70	4	0.2
71 - 80	1	0.0
81 - 90	1	0.0
91 - 100	1	0.0
Totals	2664	100.0

TABLE 14

Percent of Teachers Perceiving Children and Youth as Having Severe Behavioral Disorders in Each of Ten Incidence Levels

Incidence Level %	Number of Teachers	Percent of Teachers
0 - 10	2486	93.4
11 - 20	137	5.1
21 - 30	33	1.2
31 - 40	7	0.3
41 - 50	1	0.0
51 - 60	0	0.0
61 - 70	0	0.0
71 - 80	0	0.0
81 - 90	0	0.0
91 - 100	0	0.0
Totals	2664	100.0

RECOMMENDATIONS

An examination of findings of this study shows that there is a definite need for educators to have skills in behavior management. Regular classroom teachers reported that one in five of their children and/or youth exhibited some degree of behavioral disorder. If the students in special education units in the districts surveyed are added to those identified by the regular teachers, then a general rule could be established that approximately one in four children and youth in the public schools needs some type or degree of help to develop behaviors that are appropriate in a given situation.

The results of this study have numerous implications for educators concerned with school district and/or teacher training programs designed to meet the needs of behaviorally disordered children or youth. Implications are also stated for consideration by personnel in charge of planning and implementing services in other community programs concerned with mental health.

Implications for Preservice and Inservice Training

1. A major portion of teachers surveyed indicated that there were children and youth in their classes who exhibited some degree of behavioral disorder; therefore, it is important that all levels of teacher training include the development and use of skills concerned with alternative educational approaches. Various techniques including the use of reinforcement, (Ullman and Krasner, 1966) active listening (Gordon, 1970) and task analysis (Smith, 1969) should be considered as useful alternatives to more traditional procedures. Teachers should be skilled in managing deviant behavior and should be able to make decisions as to which methods to employ with a student in a given situation. In addition, teachers should have learned in preservice and/or inservice training that there are many ways of adapting the presentation of the curriculum to meet the needs of each student.
2. Each teacher must accept the responsibility for behavior change as well as the cognitive development of each student. Behavior management and change must be considered a charge of <u>each</u> teacher, not just of specialists such as special education teachers, counselors, and/or administrators.
3. Educators should strive to gain a knowledge of the dynamics of their interaction with children and classroom organization so that they can continuously evaluate behaviors which may be precipitating various negative responses from the students.
4. Educators must be able to define behaviors that are appropriate in a given environment -- not apply a single standard of appropriateness for all students. The age, sex and cultural norm should be considered in determining appropriate behavior for a student. Teachers should be aware of their own norms and expectations in making valid judgements

regarding a student's behavior, e.g., Is the behavior disturbing to me or is it the behavior of a disturbed student?

Since it is undesirable as well as impossible to provide an individualized special education program for each child and/or youth identified as behaviorally disordered, it is important that preservice and inservice teacher education programs include academic and practicum experiences concerned with the techniques of behavior management. These techniques may be utilized by the teacher in providing for the student in the regular classroom. They may also be employed in a preventive type program for students with mild or transitory problems.

Implications for Related Community Agencies

1. There is a need for programs designed to improve the mental health of children and youth. Current community mental health programs, which are primarily for adults, should be expanded to provide services for children and their families.
2. Efforts should be made to develop mental health services for all members of the community. Further study and discussion of teachers' perceptions of the behaviors of male students, particularly male, black students are apparent priorities. For all degrees of involvement (mild, moderate or severe), all grade levels and all identified groups, these children were more frequently identified as having behavioral problems. The services of professional workers in mental health agencies may be useful in assisting educators, parents and other community members to learn of various cultural and sexual norms and their possible effect on classroom behavior.
3. Mental health professionals should become more aware of the dynamics of the environment in which children spend a major portion of their day -- the educational institution.

Implications for School Districts

Consideration should be given to the following trends in this study:

1. There are certain age and population groups of children and/or youth that are more frequently identified as needing help with behavior problems. A higher percentage of students in the upper middle grades (3-5) and in the ninth grade were reported as exhibiting behavioral disorders than were students at other grade levels.
2. For all grades and identifying groups, fewer females than males were identified as needing special services for behavioral disorders; therefore, instructional personnel, materials, and curriculum should be selected with the expectation that special help programs will contain a large percentage of males. Academic materials such as the high interest, low vocabulary reading series focus on less traditional topics and have been found to motivate young males who have previously shown little interest in reading.

3. All teachers should have supportive services to assist them in designing behavior management strategies. In order to meet the needs of the many children and youth in the schools who have been perceived by teachers as exhibiting some degree of behavioral disorders, many role descriptions of support personnel need to be redefined. Although numerous personnel have been employed in the 70's to assist teachers in the education of children and youth, little effort has been expended to coordinate the activities of supportive personnel in order to assure the maximum utilization of their services by learners and/or by teachers. Support personnel frequently employed for the purpose of assisting teachers with the management of children's behavior are delineated in Figure 12. Primary and secondary responsibilities in relation to the various types of educational programs are suggested.

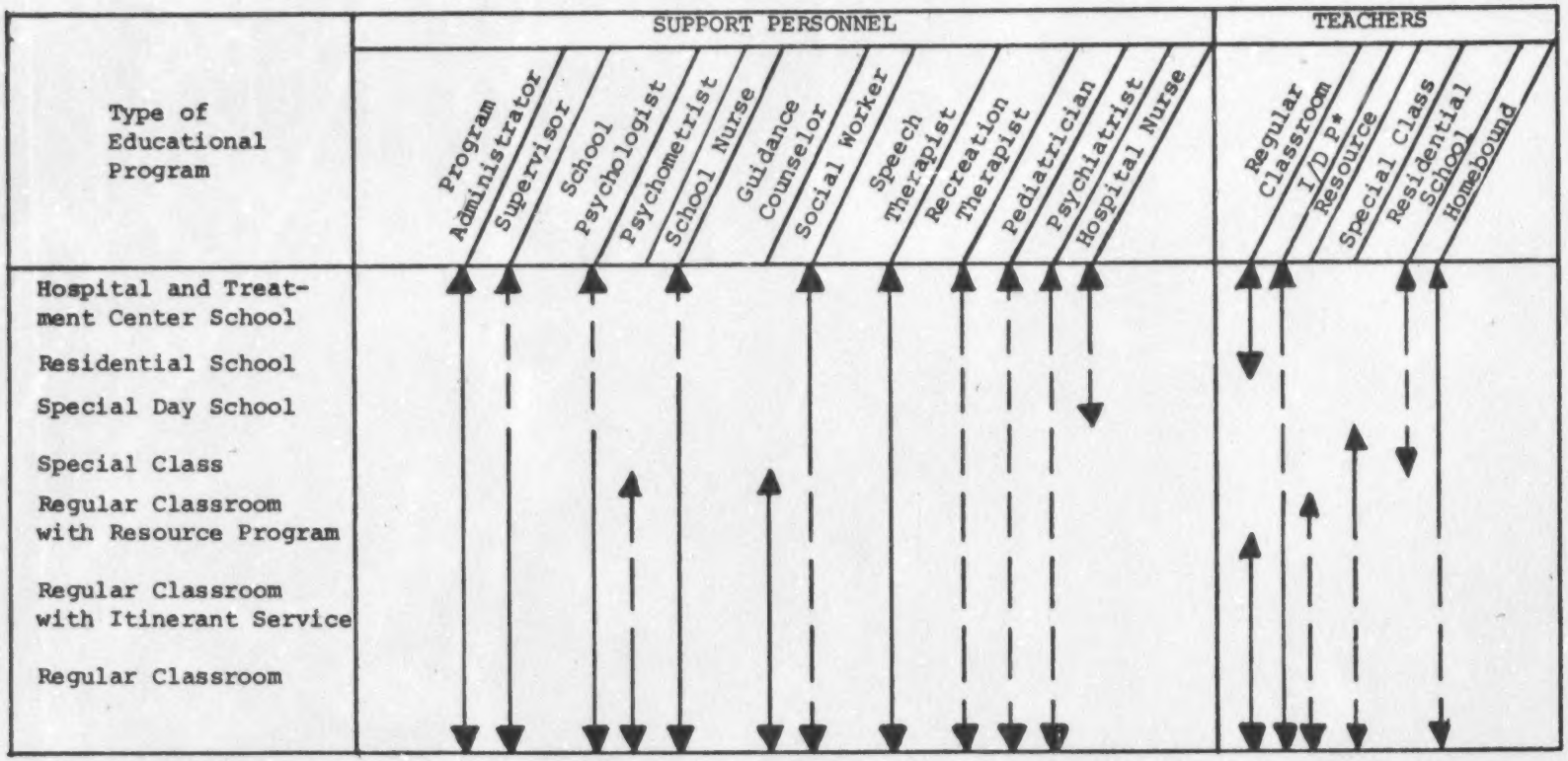
The overlap in types of programs, for which the various educational team members have responsibility, results in a variety of educational alternatives being available to children and youth. Children and youth with behavioral disorders can exhibit a wide range of behaviors; therefore, a support team with varied orientations and training is desirable in constituting optimal educational programs. The responsibilities of the various educational team members for programs for behaviorally disordered children and youth include:

Support Personnel

1. Program administrator
   - A. Oversee the scope and nature of the program, including planning, implementation, and evaluation.
   - B. Observe and participate in behavioral management strategies.
   - C. Communicate with other district and professional personnel concerned with programs for behaviorally disordered children and youth.
2. District level supervisor
   - A. Implement district level mandates which are specific to programs for behaviorally disordered children and youth.
   - B. Initiate program and staff training procedures.
   - C. Communicate with district and community personnel concerned with the program.
   - D. Provide on-going program evaluation.
3. School psychologist
   - A. Develop procedures for screening, identification, and evaluation.
   - B. Assist teachers and other educational personnel in the development of programs, staff, and child evaluation criteria.
   - C. Supervise evaluative procedures.

FIGURE 12

Team Members for Educational Programs
for Behaviorally Disordered Children and Youth:
Delineation of Responsibilities



Solid line includes all programs for behaviorally disordered children and youth for which team member has primary responsibilities.

Broken line includes all programs for behaviorally disordered children and youth for which team member has secondary responsibilities.

*Itinerant/Diagnostic Prescriptologist

4. Psychometrist
   A. Carry out screening and identification procedures
   B. Collect evaluative data
5. School nurse
   A. Facilitate referrals for medical and/or social services for students.
   B. Serve as a consultant on matters related to child development, especially in the physical and emotional/social areas.
   C. Serve as liaison between community agencies, family and the school.
6. School guidance counselor
   A. Observe and participate in behavior management strategies.
   B. Consult with teachers with regard to specific interaction techniques designed to assist the student.
   C. Serve as liaison between teachers and school psychologists relative to requests for assessment/diagnostic procedures for specific children or youth.
   D. Provide on-the-spot counseling for students and/or teachers.
7. Social worker
   A. Serve as liaison between student, family, community agencies, and the schools.
   B. Coordinate social services for the student and his family.
   C. Consult with families to assist them in child rearing practices.
   D. Contact social and medical agencies regarding referrals from the school.
8. Speech therapist
   A. Assist students in developing speech and/language skills.
   B. Consult with teachers as to specific techniques and strategies to facilitate speech and language development.
   C. Observe and participate in behavioral management strategies.
9. Recreation therapist
   A. Assist the student in developing motoric and social skills.
   B. Consult with teachers as to specific techniques and strategies to facilitate self expression and coordination.
10. Pediatrician
   A. Provide for students' physical well being.
   B. Make referrals to other medical specialists.
   C. Evaluate medical problems of referral from educational personnel.
   D. Participate in behavior management strategies in conjunction with medical treatment, e.g., drug therapy.
   E. Communicate to educational personnel the specific medical needs of students.

11. Child Psychiatrist
    A. Consult with program director and staff.
    B. Participate in behavior management strategies based on medical practices, i.e., drug therapy.
12. Hospital nurse
    A. Implement school medical programs.
    B. Observe and participate in behavior management strategies.
    C. Serve as liaison between educational specialist and other medical personnel.

Teachers

1. Regular classroom
    A. Provide for the education of all students so that each student can realize maximum potential in intellectual, physical and social/emotional development.
    B. Initiate referrals for students having difficulty in related intellectual physical, and/or social/emotional areas.
    C. Implement the behavioral management program prescribed for each student.
2. Itinerant and/or Diagnostic Prescriptologist
    A. Provide teachers and/or students with special assistance in academic and social areas.
    B. Make additional referrals for students who are unable to meet normal academic and/or social expectations.
    C. Develop and demonstrate behavioral management techniques.
3. Resource
    A. Provide specific intervention to assist individuals or small groups of students with academic and/or social deficits.
    B. Consult with regular classroom teachers regarding curriculum and management alternatives.
    C. Make additional referrals for students who are unable to meet reasonable academic and/or social expectations.
4. Special Class
    A. Provide for the intellectual, social/emotional and physical growth of individuals.
    B. Develop and implement appropriate behavioral management strategies to facilitate social and/or academic growth.
    C. Consult with other professional team members.
    D. Make referrals for educational, medical and/or social services.
5. Residential school
    A. Design educational programs for the student within the institution.
    B. Serve as a team member in coordinating the total program.

C. Maintain lines of communication with the community schools in order to facilitate the acceptance and return of the student to an appropriate community day school program.

6. Homebound
   A. Provide home instruction for children and/or youth with severe behavioral disorders.
   B. Serve as liaison between the school program, the student and his family.
   C. Facilitate the entry or re-entry of the student into the community schools.

The descriptions of professional roles provided above are only initial attempts at defining the major responsibilities of the various support personnel who may by employed. District leadership personnel will, of necessity, need to expand and define these basic responsibilities to meet their specific program requirements.

The numerous recommendations, which are outlined in this report, an obviously quite general in nature. They are intended to serve as a point of departure for local school district personnel engaged in developing programs for children and youth with behavioral disorders. Each districts' program planning committee should consider local resources and priorities in its attempts to design and develop successful programs for these children and youth.

APPENDIX A

PLEASE PRINT

Teacher's name _____

Your age: Under 20 ☐ 20 - 25 ☐ 26 - 30 ☐ 31 - 40 ☐ 41 - 50 ☐ 51 & over ☐

Sex: Male ☐ Female ☐

Race: Spanish American ☐ Black ☐ White ☐ Other ☐

Number of years of teaching experience:

1st year ☐ 1 - 2 ☐ 3 - 5 ☐ 6 - 10 ☐ 11 - 20 ☐ over 20 ☐

Academic degree(s) completed (check)

Bachelor's _____	Master's _____	Doctorate _____
Major: _____	Major: _____	Major: _____

Presently working toward an advanced degree: Yes____ No____

If so, your major field is: _____

District _____ School _____

Grade level or estimated grade level, if ungraded _____

THE COMPOSITION OF YOUR CLASS OR GROUP

1. The total number of students in your class or group

   a. Number of Males ☐ Number of Females ☐

   b.

Males		Females	
# of Spanish Americans	☐	# of Spanish Americans	☐
# of Whites	☐	# of Whites	☐
# of Blacks	☐	# of Blacks	☐
# of Other	☐	# of Other	☐

I. Number of children or youths in your class or group not considered behavior disordered ☐

II. Definition (Mild behavior disorder) - Children or youths with behavior disorders who you believe can be helped adequately by their regular class teacher and/or other school resource personnel through periodic counseling and/or short term individual attention and instruction.

A. Total number of children or youths in your class or group fitting the above description for mild behavior disorder ☐

1. Number of Males (Mild) ☐

   Number of Females (Mild) ☐

2. For Males (Mild)

   # of Spanish Americans ☐

   # of Whites ☐

   # of Blacks ☐

   # of Other ☐

   For Females (Mild)

   # of Spanish Americans ☐

   # of Whites ☐

   # of Blacks ☐

   # of Other ☐

3. Total number in this same group (Mild behavior disorder) who you consider to be achieving below their appropriate grade level. ☐

III. Definition (Moderate behavior disorder) - Children or youths with behavior disorders who you believe can remain at their assigned school but require rather intensive help from one or more specialists (i.e. counselors, special educators, etc.) and/or specialists from community agencies (mental health clinics, diagnostic centers, etc.)

A. Total number of children or youths in your class or group fitting the above description for moderate behavior disorder ☐

1. Number of Males (Moderate) ☐

   Number of Females (Moderate) ☐

2. For Males (Moderate)

   # of Spanish Americans ☐

   # of Whites ☐

   # of Blacks ☐

   # of Other ☐

   For Females (Moderate)

   # of Spanish Americans ☐

   # of Whites ☐

   # of Blacks ☐

   # of Other ☐

3. Total number in this same group (Moderate behavior disorder) who you consider to be achieving below their appropriate grade level. level. ☐

IV. Definition (Severe behavior disorder) - Children or youths who you believe have a behavior disorder requiring assignment to a special class or special school.

A. Total number of children or youths in your class or group fitting the above description for severe behavior disorder ☐

1. Number of Males (Severe) ☐

Number of Females (Severe) ☐

2. For Males (Severe)

# of Spanish Americans ☐

# of Whites ☐

# of Blacks ☐

# of Other ☐

For Females (Severe)

# of Spanish Americans ☐

# of Whites ☐

# of Blacks ☐

# of Other ☐

3. Total number in this same group (Severe behavior disorder) who you consider to be achieving below their appropriate grade level. ☐

Total number of children or youths in your class or group (This total result is obtained by adding catagories I, II, III, & IV and should equal the total number of children in your class or group) ☐

Comments:

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